The PEEHIP ADVISOR
PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

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Group Benefits

By Marcus H. Reynolds

There has been a great deal of discussion regarding changes made in rate structures at the PEEHIP Board meeting on May 6, 2010, particularly concerning the elimination of combined allocations. Hopefully, a brief discussion of the concept of "group benefits" will help put some of these changes into perspective.

The basic premise of group benefits is to spread the "risk." A group has an average risk that is much less than the majority of the individuals in that group at any given point in time. Conversely, many individuals have a risk that is less than the group at a certain point in time. Spreading the risk gives constant protection for all members of the group at all points in time.

All educators are members of the PEEHIP group. Some members are single, some are divorced, and some are widowed. Some members are married to doctors, some to lawyers, some to spouses who are unemployed, some to educators, and some to educators who are members of the group. The group's obligation is the same to each and every member and that is to provide benefits to **the members**. Groups usually offer an opportunity for its members to purchase additional benefits for their families usually at a subsidized cost. All groups require dependents with their own benefits to use those benefits first. If a dependent of a member of a group had their own benefits, then that dependent is required to use their own coverage before any family coverage would pay.

Before PEEHIP was established in 1983, educators had no state-sponsored group plan. Teachers were given an insurance allocation, $25 per month, in 1982. They could use that allocation for any insurance they chose and spouses could pool their allocations because the state was simply giving money and not providing benefits. The benefits available to employees as well as the cost of those benefits varied from school system to school system. None had better benefits than PEEHIP, but many were priced differently due to the system's unique "point in time." Over time, all local systems joined PEEHIP as their costs increased.

In 1983 when the PEEHIP group was established, everyone knew that combining of allocations would have to be eliminated from the group plan at some point. People tend to want the benefits of a group when they need them and the rates of an individual when it is to their benefit. This will simply not work in a group plan. No one in their right mind would trade the stability and benefits of

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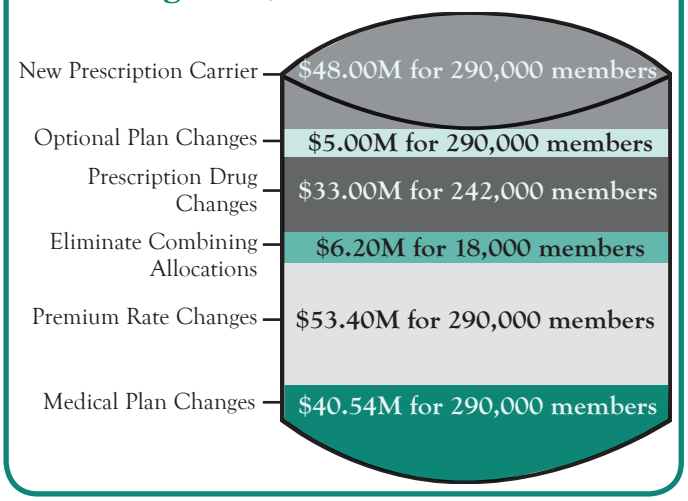
Changes in PEEHIP Premiums, Benefits & Policies

The PEEHIP plan received level funding from the Legislature to provide health insurance coverage to approximately 290,000 active and retired members and their covered dependents for FY 2011. This amount was not enough to maintain current coverage at current costs and left the PEEHIP plan $255 million short for the plan year beginning October 1.

The PEEHIP Board of Control met on May 6 and voted to make changes to PEEHIP that will increase revenue by an estimated $186 million with an additional $60 million to be taken from the PEEHIP Trust Fund. Failure of the Board to act in making these critical decisions would have led to a financial crisis and jeopardized the sustainability of the PEEHIP program.

The revenue generating decisions that were approved were done with the intent to provide the best benefits to our members at the lowest cost while keeping the PEEHIP fund financially sound. The Board made changes in all areas but targeted the changes to specifically address the imbalances between PEEHIP and the State Employees' Health Insurance plan. This brought the PEEHIP copayments and deductibles to a level equal or slightly better than other reputable large group plans. The chart below shows the amount of revenue generated and member impact from each category to generate the revenue needed to fill the $255 million deficit. ■

Filling the $255 Million Deficit



Group Benefits

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PEEHIP for the old "everyone for themselves" approach. Yet, educator spouses want to be treated as part of the group for purposes of allocation and not part of the group for dependent benefit coverage.

The same argument exists among members with dependent coverage. Some members have 1 or 2 dependents while others may have 5 or 6 or even 10 dependents, in some cases. It is clearly in the overall interest of the group as a whole to have a uniform dependent rate. If dependents were charged per head, approximately 33 percent of those carrying dependent coverage would receive nominal discounts in rates, another 33 percent would receive nominal increases, while the remaining 33 percent would receive substantial increases, some being priced out of the insurance market altogether.

If we did not have PEEHIP and each educator employee received the FY2009 $307 state allocation (see pie chart), members could expect to pay an additional $200-$250 for single coverage as opposed to the new $15 member payment. Spouses could combine allocations and still expect to pay an additional $400 to $500 for comparable PEEHIP coverage in the private market as opposed to paying $177 for family coverage.

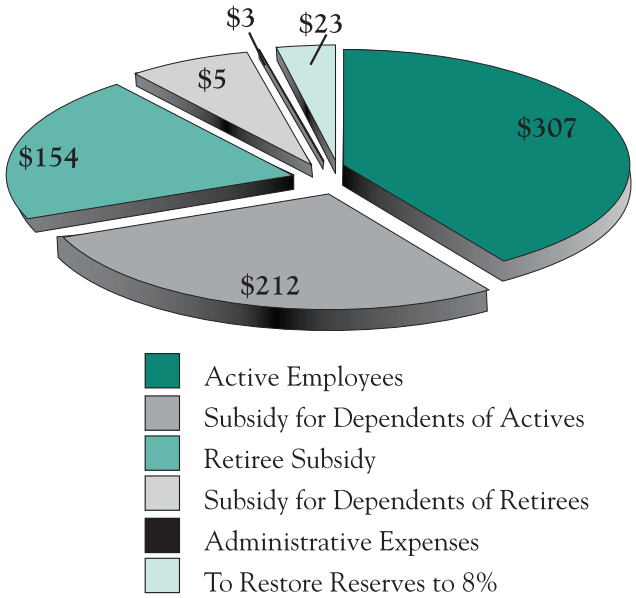
While no one likes to pay more money, the benefits of stable group coverage with excellent benefits are well worth the cost and clearly in the best interest of Alabama educators. To the 18,000 members (9,000 couples) out of the 290,000 PEEHIP members adversely affected by the phase out of the combining allocations, the PEEHIP staff understands your position and the fact that increased expenses are never pleasant. While you may feel penalized, please be mindful that you are not being treated unfairly and that these changes were necessary to maintain the sustainability of the PEEHIP program.

As educators, you all know that whether it is a classroom, a bus, or a cafeteria full of students, your duty is to protect all the students and the institution of public education. Some students are more difficult or challenging than others; yet, you cannot let one child or a group of children adversely affect the whole classroom, bus, or cafeteria. Do some individuals get more time and attention than others? Clearly the answer is "yes." You make every effort to make every individual child a success but not to the detriment of the class. Those individuals who are not successful generally blame the teacher. Everyone else knows that is far from the truth.

The PEEHIP staff is no different. We made recommendations to address a real funding crisis and to ensure the sustainability of the plan in the fairest way possible considering the overall group of 290,000 covered lives. Certainly, some were impacted more than others. Some would brand us as uncaring and unsympathetic. That, too, is far from the truth. ■

PEEHIP State Funding Breakdown

PEEHIP received level funding from the Legislature of $752 for each active employee for FY2011. This amount is not only used to cover the cost for active employees, but must also cover the cost to provide insurance coverage to all active and retired employees over and above the premium paid by the employee and maintain an 8% reserve level. This chart shows the breakdown of how the funding rate of $752 was used for PEEHIP in FY2009. ■



Approved Benefit Changes

Copayment & Deductible Changes	New Copayments/ Deductibles Beginning October 1, 2010
Physician Office Visit Copay	$ 30
Medical Emergency Room Visit Copay	$150
Outpatient Surgery Facility Copay	$150
Inpatient Hospital - Copay per admission - Daily Copay, days 2 - 5	 $200 $ 25
Lab Copay	$ 5
Major Medical Deductible: - Single - Family Maximum	 $300 $900
Prescription Drugs (30 day supply): - Generic Copay - Preferred Drug Copay - Non-Preferred Drug Copay	 $ 6 $ 40 $ 60
Prescription Maintenance Drugs (90 day supply): - Generic Copay - Preferred Drug Copay - Non-Preferred Drug Copay	 $ 12 $ 80 $120

Approved Premium Changes

PEEHIP Hospital Medical or VIVA Health Plan	New Premium Rates Beginning October 1, 2010
Active Employees:	
- Single	$ 15
- Family	$177
COBRA and Leave of Absence:	
- Single	$ 434
- Family	$1,044

Retired Members not subject to sliding scale (based on 25 years of service) or Surviving Spouse/Dependent:

	Retirees	SS/Dep.
- Single Non-Medicare Retiree	$146	$701
- Family Non-Medicare Retiree & Non-Medicare Dependent(s)	$381	$890
- Family Non-Medicare Retiree & Only Dependent Medicare Eligible	$245	$859
- Single Medicare Retiree	$ 10	$369
- Family Medicare Retiree & Non-Medicare Dependent	$245	$558
- Family Medicare Retiree & Only Dependent Medicare Eligible	$109	$527

PEEHIP Supplemental Medical Plan	New Premium Rates Beginning October 1, 2010	
Active & Non-Medicare (NM) Retired Members or COBRA and Leave of Absence (LOA):		
	Active/NM Retirees	COBRA/LOA
Single or Family	$0	$152

Tobacco Surcharge	New Premium Rate Beginning October 1, 2010
Active & Retired Members:	
- Member or Spouse	$27

Tobacco Surcharge applies to the hospital medical and HMO plans only

Dental Plan	New Premium Rates Beginning October 1, 2010
Active & Retired Members:	
- Family	$45
- Single (no change in premium)	$38

Note: No change in premiums, single or family, for the Cancer, Indemnity and Vision plans.

Active or retired members who are not enrolled in the hospital medical or HMO plan and are not combining allocations with their spouse can use their state allocation for the optional plans or the PEEHIP Supplemental Medical Plan. Full-time active employees will continue to receive all 4 optionals at no cost and retirees will continue to receive 2 optionals at no cost. If active or retired members choose to use their state allocation for the PEEHIP Supplemental Medical Plan in lieu of the optional or PEEHIP Hospital Medical Plan, the active or retired allocation will continue to cover the full cost of the PEEHIP Supplemental Medical Plan.

Eliminate Combining of Allocations 3-Year Phase-Out	New Premium Rates Beginning October 1, 2010

Terminate the combining allocation program with all current participating members to be grandfathered in and premium rate increases for this grandfathered group will be pro-rated over a 3-year period in increments of 1/3 of the $177 family premium. No married couples will be able to begin combining allocations effective 10/1/2010. (*The rates in years 2 and 3 below assume no further rate increases. If rates change, the premium amounts shown below will change.)

Active Members Combining Allocations and Active & Retired Members (under & over 65) Combining Allocations:	
- Year 1: Oct 1, 2010 – Sept 30, 2011	$ 59
- Year 2: Oct 1, 2011 – Sept 30, 2012	*$ 118
- Year 3: Oct 1, 2012 – Sept 30, 2013	*$ 177

Retired Members Combining Allocations not subject to sliding scale (based on 25 years of service):

Year 1: Oct 1, 2010 – Sept 30, 2011:	
- Retiree & Dependent < 65	$237
- Retiree < 65 & Dependent > 65	$127
- Retiree > 65 & Dependent < 65	$127
- Retiree & Dependent > 65	$ 36
Year 2: Oct 1, 2011 – Sept 30, 2012:	
- Retiree & Dependent < 65	$309
- Retiree < 65 & Dependent > 65	$186
- Retiree > 65 & Dependent < 65	$186
- Retiree & Dependent > 65	$ 72
Year 3: Oct 1, 2012 – Sept 30, 2013:	
- Retiree & Dependent < 65	$381
- Retiree < 65 & Dependent > 65	$245
- Retiree > 65 & Dependent < 65	$245
- Retiree & Dependent > 65	$109

Note: Members who retired on or after October 1, 2005, are subject to the sliding scale premiums which are based on years of service and the cost of the insurance program. A chart illustrating the new sliding scale premiums will be posted on the PEEHIP Web site.

Couples can opt to change to two single policies during the Open Enrollment period if that is more cost effective. However, if the couple has additional dependents covered on their family plan, they must use both allocations for the family hospital medical plan and cannot use one of the allocations towards the optional plans. Combining allocation couples can purchase optional plans at the monthly rate. ■

Approved Policy Changes

- New Prescription Drug Carriers effective October 1, 2010
  - **MedImpact** is replacing Express Scripts for the Core pharmacy program
  - **BioScrip** is replacing CuraScript as the Specialty pharmacy program.
  - These new carriers will save PEEHIP $48 million each year over the three-year contract.
  - Your contract numbers will remain the same. PEEHIP will issue new insurance cards to members in September 2010. **Note:** You will need to keep and use your old card until September 30, 2010, and begin using the new card October 1, 2010.
- **Blue Cross Blue Shield of Alabama** will continue to administer the Hospital Medical Program and the Flexible Spending Account Program.
- **Southland National** will continue to administer the four optional coverage plans (Cancer, Dental, Indemnity and Vision).
- **VIVA Health Plan** will continue to be the HMO carrier.
- **The Wellness and Weight Watchers Program:** The PEEHIP Board voted to reinstate the Wellness and Weight Watchers program. Members and covered dependents will be eligible to once again participate in free health screenings provided by the Public Health Department nurses, and PEEHIP will offer the Weight Watchers program to allow eligible members to participate in a 15-week Weight Watchers program for only $85. Members who have a body mass index of 25 or more will be eligible to participate in the PEEHIP Weight Watchers program. You must attend at least 12 out of the 15 sessions to get reimbursement. Additional information can be obtained on the Public Health Department website at www.adph.org/worksitewellness or by calling 800-252-1818 and asking for the Wellness Division. The wellness screenings are intended to assist employees and their families identify health risks and receive early and necessary treatment and ultimately lower health care costs.

Federal Health Care Reform Time Line

The **Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act** were signed into law on March 23 and March 30, 2010, respectively, which will significantly impact PEEHIP by mandating changes in many areas of the program.

Effective October 1, 2010

- Adult Children – PEEHIP is required to offer and extend dependent hospital medical coverage (at the member's option) to adult children up to age 26 only if the adult child is not eligible for other employer sponsored group hospital medical coverage. The normal family hospital medical rate will be charged to anyone who enrolls an eligible adult child between the age of 19-26. **No additional charge will be required.** Members will be allowed to enroll their adult child(ren) during the annual open enrollment period which begins July 1 and ends August 31, for an October 1 effective date.
- Pre-Existing Conditions – PEEHIP is prohibited from imposing a waiting period for enrollees under age 19 who have pre-existing conditions. This applies to both contract holders and dependents. PEEHIP currently imposes a 270 day waiting period only when enrollment occurs outside of the annual Open Enrollment period. This waiting period will be removed.
- Lifetime Dollar Limits – PEEHIP is prohibited from having lifetime dollar limits on essential health benefits covered under major medical. PEEHIP currently has a $1 million lifetime maximum for major medical services which will be removed October 1, 2010.

Effective January 1, 2011

- Flexible Spending Accounts (FSA) – Reimbursement of over-the-counter drugs from the Health Care FSA is prohibited. A member can incur expenses for over-the-counter drugs through December 31, 2010, and file for reimbursement. Expenses for over-the-counter drugs incurred after this date cannot be reimbursed through the FSA.

Effective October 1, 2013

- Flexible Spending Accounts (FSA) – Health Care FSA annual contribution must be capped at $2,500 a year. PEEHIP currently allows a $5,000 annual Health Care FSA contribution.

Effective October 1, 2014

- Annual Benefit Limits – PEEHIP is currently awaiting clarification from the federal government regarding limits on the number of visits, days, etc.
- Pre-Existing Conditions – PEEHIP is prohibited from imposing a waiting period for all enrollees regardless of age.
- Adult Children – PEEHIP must offer and extend dependent hospital medical coverage (at the member's option) to adult children up to age 26 regardless if the adult child is eligible for other group hospital medical coverage.

Effective October 1, 2018

- Excise Tax on High Cost Employer-Sponsored Health Coverage (commonly referred to as "Cadillac Tax") – A 40% excise tax on health coverage cost that exceeds $10,200 for a single coverage and $27,500 for family coverage, indexed for inflation. ■

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